BHSF Form 1-L SSI
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II

Louisiana Medicaid Program

SSI Recipient Application

Long-Term Facility Care, Home and Community Based Services (HCBS), or Program of All Inclusive Care for the Elderly (PACE)

Date of initial request _____
(For Agency Use Only)

What language do you speak best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (specify)* _____
What language do you write best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (specify)* _____

1. Name of Applicant (person who needs long-term facility care, Home and Community Based waiver or PACE).

   Name (First, Middle Initial, Maiden, Last) _____

   Social Security #_____ Date of Birth_____

   Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

   Is the person in need of long term care a Veteran? ❑ Yes ❑ No If **yes**, VA Claim# _____

   Railroad Retirement#_____

   Residence address_____City_____State____Zip code_____

   Mailing address_____City_____State____Zip code_____

2. Who is the person responsible for handling the applicant's affairs?

   Name _____ Daytime phone # (____) _____

   Cell phone # (____) _____E-mail address _____

   Mailing address_____City_____State____Zip code_____

   Relationship to the applicant _____Does this person have power of attorney? ❑ Yes ❑ No

   If **no**, does someone else have power of attorney? ❑ Yes ❑ No If **yes**, who? _____

3. A. What is the applicant's current facility status? ❑ Lives in a nursing facility ❑ Plans to enter a facility

      Facility name _____ Date Entered the Facility _____

   B. Is the applicant applying for Home and Community Based Services (waiver)? ❑ Yes ❑ No

      Has the applicant been offered an opportunity (slot) for HCBS (waiver)? ❑ Yes ❑ No

      What type of HCBS (waiver) is the applicant applying for?

      ❑ Adult Day Health Care ❑ Children's Choice ❑ Elderly/ Disabled Adult ❑ New Opportunities

      Name of case management agency_____

   C. Is the applicant applying for PACE? ❑ Yes ❑ No

4. Did the applicant move to Louisiana from another state? ❑ Yes ❑ No If **yes**, when? _____
   Does he or she intend to remain in Louisiana? ❑ Yes ❑ No

5. Does the applicant have a legal spouse who lives at home and/or any children under age 18?
   ❑ Yes ❑ No If **yes**, give us the following information about these people.

Name (First, Middle Initial, Last)	**Social Security #**	**Date of Birth**			**Relationship to Applicant**
		month	**day**	**year**	

6. Does the applicant or legal spouse have any income **other** than SSI (Supplemental Security Income)?
   ❑ Yes ❑ No What is the source and amount of the income? _____
   If applying for long-term facility care, does the applicant wish to contribute part of this income to the legal spouse and/or any children under age 18? ❑ Yes ❑ No

7. Does the applicant or legal spouse work? ❑ Yes ❑ No If **yes,** give the name of employer and gross wages (income before any deductions).____

   How often paid? _____

8. Did or will the applicant or his or her legal spouse receive any lump sum of money like an insurance or lawsuit settlement, inheritance, or retroactive Social Security payment? ❑ Yes ❑ No

   If **yes**, who? _____Amount $_____ When? _____
   From whom? _____For what reason? _____

9. Does the applicant and/or his or her legal spouse have any bank accounts or cash? ❑ Yes ❑ No
   Name(s) on the account _____
   Name and address of the bank or financial institution _____
   Account Number _____Balance $_____

10. Has the applicant or legal spouse ever created a trust, placed any items in trust, or been named as the beneficiary of a trust? ❑ Yes ❑ No A copy of the trust will need to be provided.

11. Does the applicant, or legal spouse own or buying the **home** in which they live or other property? ❑ Yes ❑ No
    If **yes**, give address or location and description of the property. _____
    _____
    _____

12. Does the applicant or legal spouse have a share in an undivided estate or heir property? ❑ Yes ❑ No

If **yes,** give the following information.

Description of the property_____

_____

Value of the property $_____Amount owed on the property $_____

Number of other heirs _____

13. Has the applicant, legal spouse, or anyone acting on their behalf sold, given away, or deeded any assets or property? ❑ Yes ❑ No If **yes**, give the following information.

What was given away, sold, or deeded? _____

To whom?_____ Date _____

14. Does the applicant have other health insurance, including Medicare supplements, that cover doctor and hospital visits? ❑ Yes ❑ No If **yes**, give the following information.

Name and address of company _____

Group/Policy # _____ Monthly Cost $_____

15. Does the applicant have life insurance with **<u>combined</u>** face value above $10,000? ❑ Yes ❑ No

If **yes**, amount? $_____ Name and address of companies_____

_____

_____Policy #(s)_____

Rights and Responsibilities

★ You state that the information you give on the application form is true and correct. You understand if you on purpose give information that is not true OR if you on purpose do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

★ You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

★ You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid.

★ You understand by accepting Medicaid, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you and/or the person(s) applying.

- ★ You understand that Estate Recovery rules call for the Department to get back or recover the money paid by Medicaid for medical services the applicant will get at age 55 or older and in certain instances involving trusts at any age. This includes payments to the nursing facility, hospitals, HCBS and PACE providers, doctors, and for prescription medicine. The estate is the property that is owned at the time of death. The Department will not recover from the estate when: 1) the applicant or their spouse is still living; 2) the applicant has a dependent child that is under age 21, blind or disabled; 3) the total paid by Medicaid is not enough to cover what it will cost to get back the money; or 4) a hardship is filed. A hardship is met when: 1) the property of the estate is the only income for the heirs; 2) the heirs have little income; or 3) there are other convincing reasons.

- ★ You understand that Medicaid will only send case information to Child Support Enforcement for medical support if you ask them to.

- ★ You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) changes in mailing or home address; 3) changes in health insurance and premiums; 4) changes in income; 5) changes in things owned by anyone who gets Medicaid who is disabled or over age 64; and 6) if a pregnancy ends.

- ★ You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

- ★ You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P.O. Box 1349 Baton Rouge, LA 70821-1349.

Signature of Applicant or Authorized Representative	Date
Signature of Spouse, if applicable	Date

If Signed with an "X"

Signature of Witness	Signature of Witness
Signature of Agency Representative	Date